Can they be helped?

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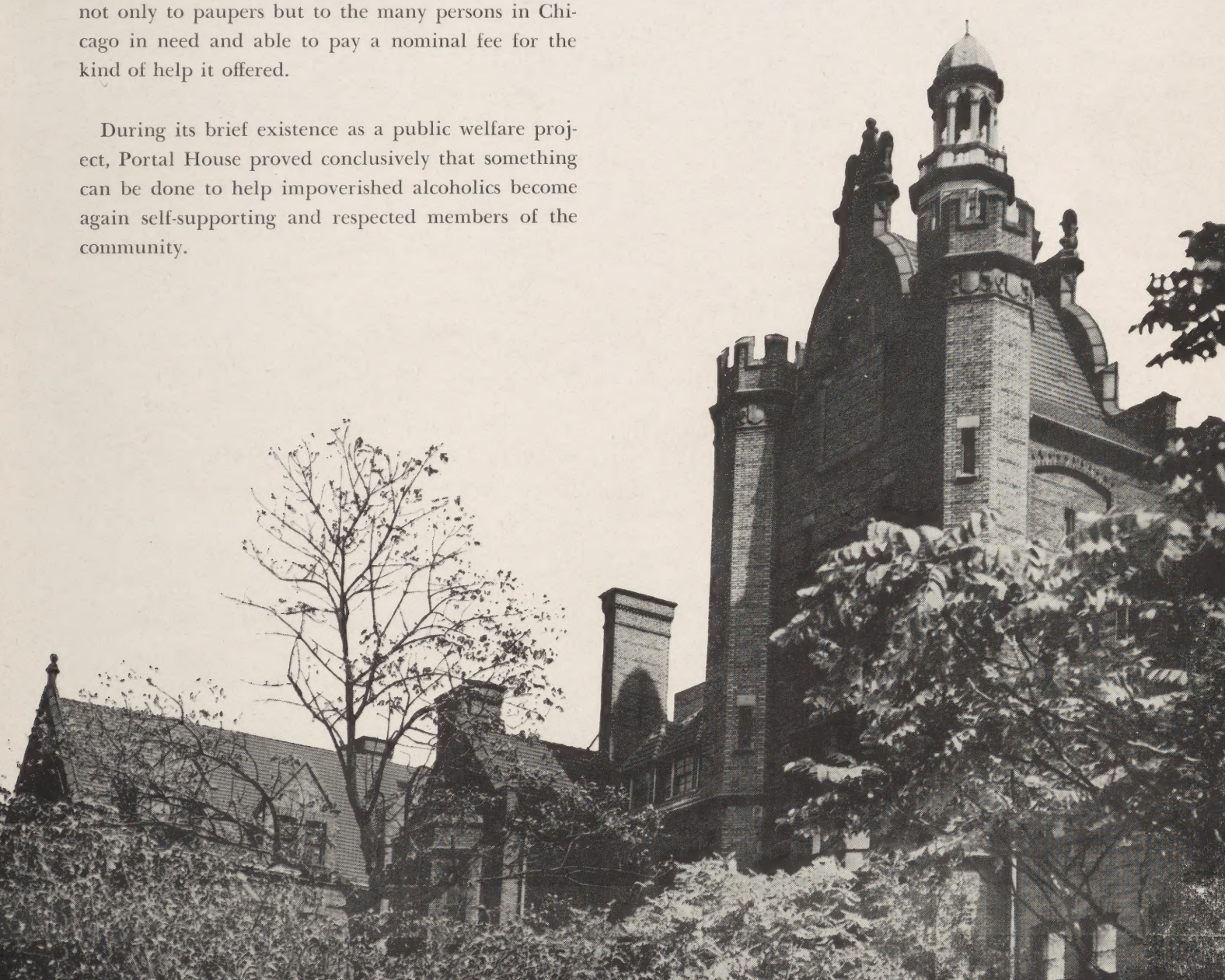
Portal House

THIS IS THE STORY OF PORTAL HOUSE—a new-type treatment center for alcoholics set up by the Chicago Department of Welfare as an experiment on June 16, 1947.

It is a heartening story. Results achieved were far beyond expectations.

At the conclusion of the experiment—one year from the date it began—Portal House, with all of its facilities and staff, was turned over to the Chicago Committee on Alcoholism, a private, non-profit organization, in order that its doors might be opened not only to paupers but to the many persons in Chicago in need and able to pay a nominal fee for the kind of help it offered.

During its brief existence as a public welfare project, Portal House proved conclusively that something can be done to help impoverished alcoholics become again self-supporting and respected members of the community.



Why Portal House?

In the first scientific study on the extent of alcoholism in major U. S. cities[1] the number of excessive, uncontrolled drinkers in Chicago was estimated to be over 100,000, most of whom were in need of treatment; more than 26,000 of these were chronic alcoholics, (i.e. they had been damaged mentally and/or physically by excessive use of alcohol).[2]

Data for this estimate were obtained from first admissions to hospitals, from autopsy and diagnostic records and similar sources. About 80% of all cases sent to Chicago's lock-ups involved alcoholism. Between 4,000 and 5,000 persons handled monthly by the Municipal Courts in Chicago came to the attention of the court because of misconduct while inebriated. In 1946, 27% of all admissions to Cook County Psychopathic Hospital were cases of chronic alcoholics.

Despite this alarming situation, no comprehensive treatment facilities existed in Chicago.

Dependent Alcoholics

These conditions in the community were reflected to a very noticeable degree in the caseload of the Department of Welfare. The Department's Medical Review Unit, conducting physical examinations of recipients and applicants, reported diagnosis of 3 to 5 cases of alcoholism daily, of which 1 to 2 cases appeared good prospects for treatment effort.

Case histories in the files of the Department pointed to alcoholism as a source of many misfortunes: breakdowns of family life, tragic economic and human waste, incalculable costs to the community.

The Department provides medical, dental and psychiatric services for all recipients who are in need. These services include facilities for diagnosis, treatment, prevention, nursing and convalescence. Convinced that alcoholics were sick people, the Department decided that they should be similarly treated.

Advisory Committee

In setting up Portal House, the Department sought the advice of nationally recognized experts. An Advisory Committee was formed whose membership comprised physicians, psychologists, sociologists, and social workers. The Committee was headed by Dr. Anton J. Carlson, eminent University of Chicago physiologist, and President of the Research Council on Problems of Alcoholism (an affiliate of the National Research Council), and Dr. Andrew C. Ivy, Vice President in charge of professional schools of the University of Illinois.[3]

Staff and Physical Set-Up

The Portal House staff consisted of a Director and an assistant, both of whom were arrested alcoholics and experienced in counseling; three counselors (non-alcoholics); one psychologist; one part-time psychiatrist (loaned by Illinois Neuropsychiatric Institute); one part-time physician; one part-time vocational counselor; an office manager and a stenographer.

Cooperating with Portal House in a consultative capacity were staff members from several divisions of the Department of Welfare. These included a case worker assigned to handling patients' social and family problems; a home economist to conduct classes on nutrition and food preparation; specialists and counselors in work therapy and occupational placement.

Members of Alcoholics Anonymous, former patients and clergymen of Lutheran, Catholic and Episcopalian faiths volunteered their services in many useful capacities.

Portal House was located on the third floor, north wing of the Department's Convalescent Home at 5059 South Vincennes Avenue. It had a capacity of 22 patients. Quarters consisted of a large dormitory—light, airy and spacious; ample bath and toilet facilities; a comfortably furnished living and dining room; private rooms for interviewing purposes; a conference room used for classes and discussions; an office; living quarters for resident staff.

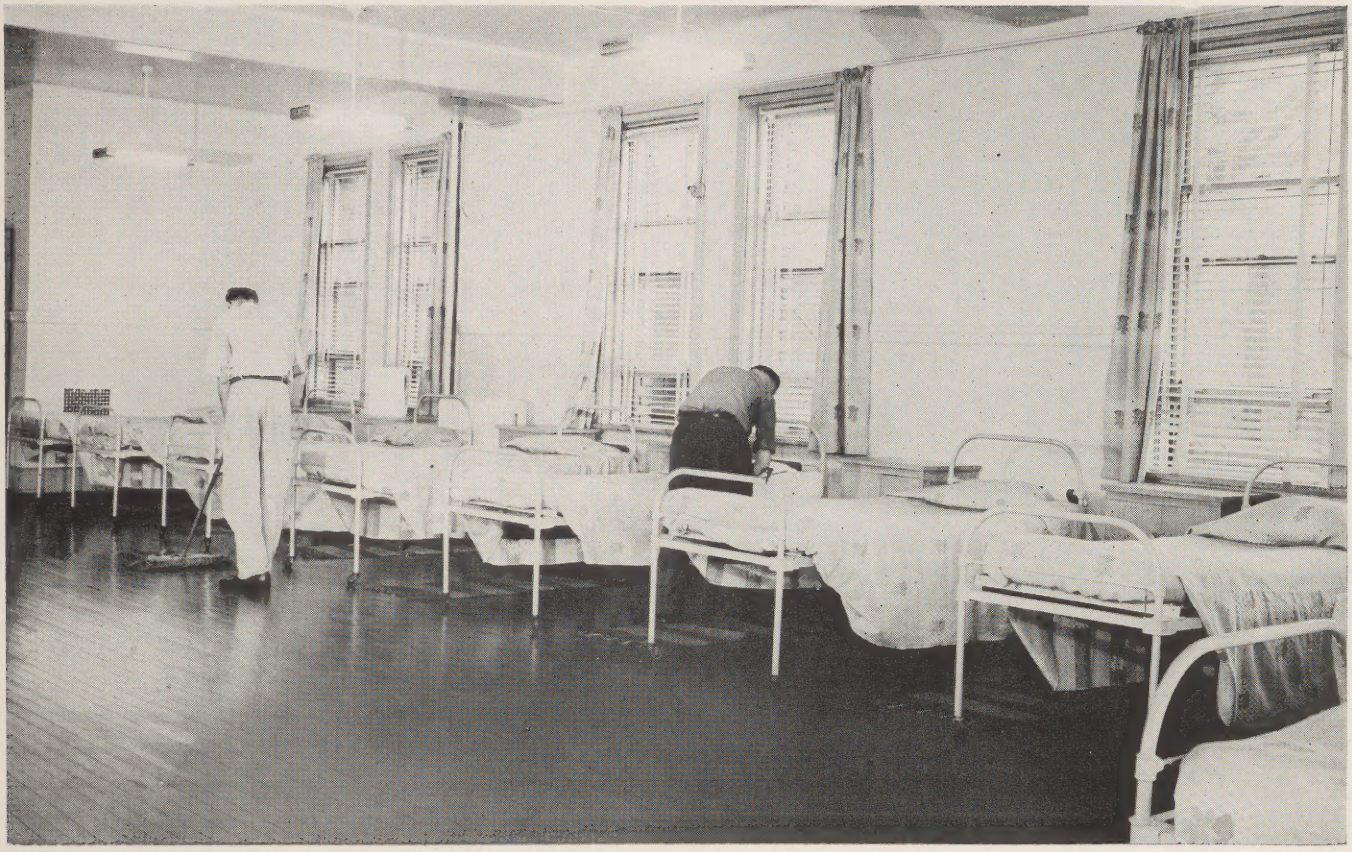
Patients were provided reading and writing materials, including non-technical publications relating to alcoholism and current periodicals. A ping-pong table, games and radio provided recreational outlets. Common eating and living room offered opportunities for close and constant community between staff and patients.

Minimal rules were established for patients' guidance and observance. The very nature of the program required an informal atmosphere in which patients were to live without self-consciousness and without a sense of strict supervision. They willingly assumed responsibility, through self-government, for maintenance of the premises and the garden, and for administering needed discipline in their own group.

[1]E. M. Jellonick, SCD, "Recent Trends in Alcoholism and Alcohol Consumption" published by Yale University, Section of Studies on Alcoholics, Laboratory of Applied Psychology, New Haven, 1947.

[2]See "Definition of Type of Alcoholics," Page 11.

[3]See Page 18 for complete roster of Advisory Committee.



Dormitory—patients making beds and cleaning quarters

Living Room—Staff conference with Comr. A. E. Rose

Selection of Patients

Policies and criteria for selection of patients were reviewed and approved by the Advisory Committee. Prospective patients were selected from families who were either recipients of assistance or applicants who were eligible for assistance. In each instance, the case worker or intake interviewer referred the prospective patient to the Department's Medical Review Unit for examination by staff physicians. If the examining physician found a history of alcoholism or a diagnosis of alcoholism, the patient was recommended for admittance to Portal House, provided he recognized his addiction to alcohol and indicated a desire to overcome it. No coercion was used.

For reasons of expediency (space, staff and budget considerations) only male patients were admitted to Portal House. Generally, the age level of patients was between 30 and 50, but at the discretion of the Director, younger and older patients were also admitted.

No patient was accepted who had a serious infection, such as tuberculosis or a communicable venereal disease. Patients were also excluded whose alcoholism was established as a symptom of serious underlying pathology, notably psychoneuroses and psychoses, or where deterioration had advanced to the extent that treatment could not insure return to self-support.

Among the first patients admitted to Portal House in June, 1947, were a doctor, lawyer, commercial artist, professional football player, traveling salesman, laborer, bartender, landscape artist, machine operator. They represented a cross section of Chicago's population. They were all men "on relief." Many of them came from Chicago's "Skid Row."

Conception of Treatment

The scope of the treatment plan was conceived to take into consideration the total personality of the addict. The program was laid out to encompass all known effective methods of treatment:

A. The experience of Alcoholics Anonymous, a voluntary national association of some 60,000 former alcoholics who attained recovery by a method of spiritual reorientation, self-discipline and fellowship. Portal House method of group discussions paralleled in the main the twelve step program of A. A., a program which in chainlike progression offers a rational basis for good living.

B. The experience of Merchant Marines' Rest Centers set up during the war. Concept of Portal House as a resident and therefore relatively thorough rather than hospital, or temporary, type of treatment program was inspired by these centers. Experience indicated that residence treatment enabled the patient more surely to follow through on each step of the recovery program with ample time under continued guidance for discussion and practice for each step.

C. The Yale Plan Clinic for Alcoholics. General counseling procedure was based on an apprenticeship served by Mr. James Hamlin (Director of Portal House, and an arrested alcoholic) at the Yale Clinic in the summer of 1945. The Clinic was the first such laboratory set up by a group of scientists for the study of all aspects of the problem of alcoholism.

Treatment Plan

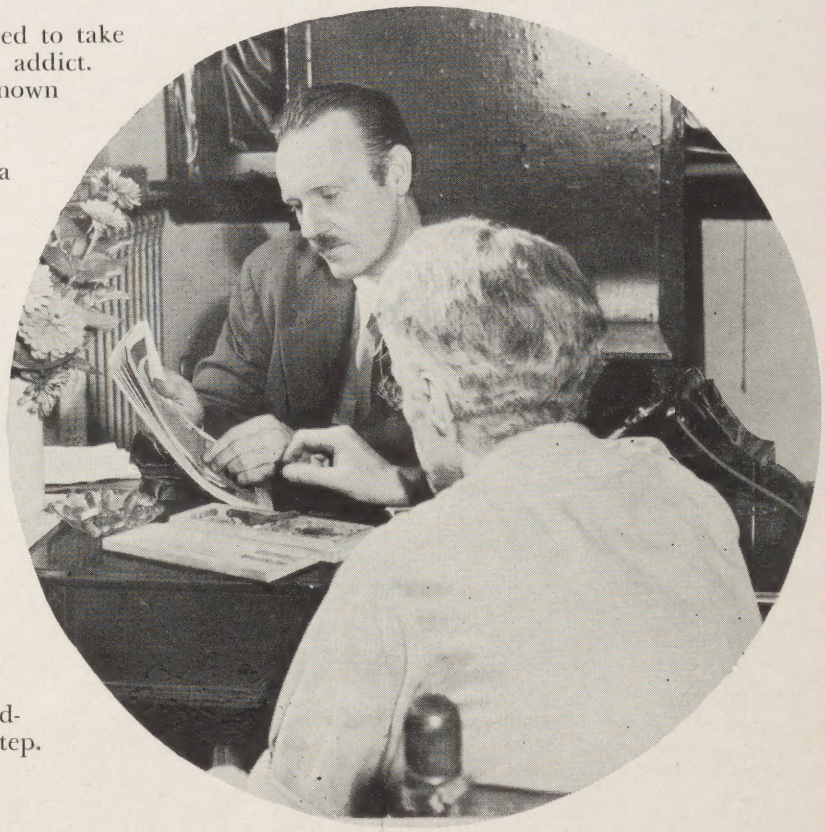
The first phase of the program required treatment lasting from five to six weeks at Portal House, during which time the patient underwent an intensive routine of counseling, testing, and work activities. This phase was followed by an "out-patient" program lasting from 30 to 90 days, after which the patient was still welcome to return to Portal House for advice or to participate in group meetings.

The ultimate goal of the treatment program at Portal House was to reeducate the alcoholic, to give him a fresh outlook and a new grip on life. The program combined an integrated plan of group discussions and intensive individual counseling, supported by medical, vocational and recreational guidance services.

Group counseling embodied the principle of ethical reeducation and retraining in attitudes, which in the case of a typical alcoholic usually involved resentments, intolerance, over-confidence, rationalism, blaming others for misdeeds of his own.

He was helped to acquire an understanding of the basic rules of responsible group living.

Director interviews new patient



Individual counseling was aimed at helping the patient to analyze his personal problems and through training in the techniques of self-analysis to gain progressively deeper insight. Work therapy contributed to the development of stable work habits through a growing recognition of the value of profitable and satisfying work experience.

Individual Counseling

Following admission, each patient was assigned to a counselor for an extensive preliminary interview, a summation of his case record, the handling and servicing of such non-alcoholic problems as the patient's social or health condition might indicate.

This was followed by a second interview in which complete details regarding patient's drinking history were recorded by one of the counselors who was an arrested alcoholic. Other interviews were scheduled at the patient's own request or as the need for them arose. During these interviews the patient was assisted in discovering the underlying factors of his illness; was given opportunity to discuss confidentially any problems with which he felt he needed help. The specific case of the individual was considered with a view toward gaining deeper personal insight into his particular problem and the best way for *him* to resolve it.

The emphasis in this phase of the program was to develop self-responsibility. The patient was never allowed to assume that his recovery could be achieved through the efforts of anyone other than himself. In all counseling relationships he was helped to reach his own decision with respect to possible choices in the solution of his problems.

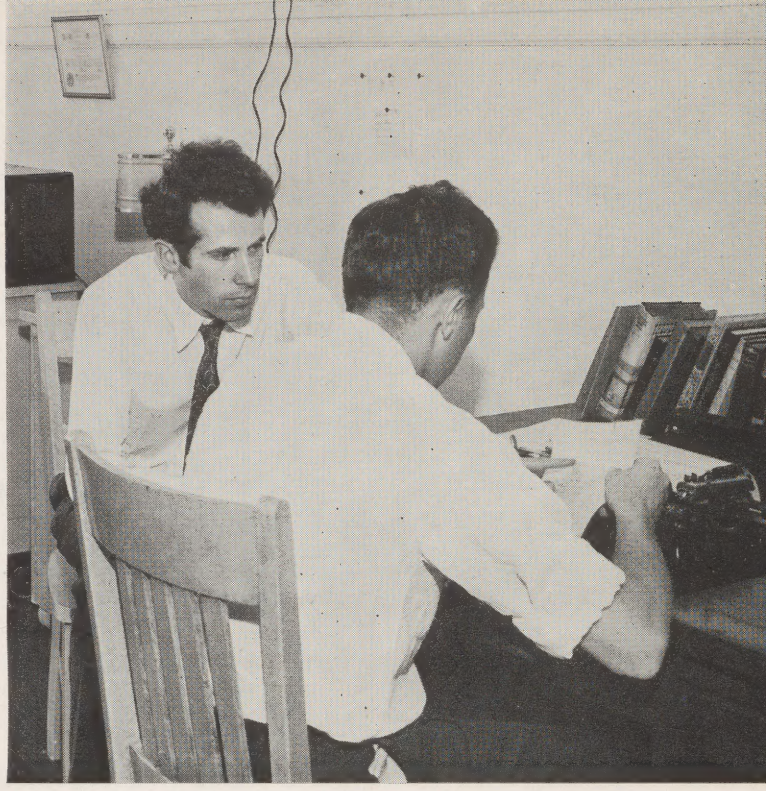
Group Counseling

A series of 18 to 30 group discussions, led by the Director of Portal House, was the core of the treatment program. Sessions lasted from 1½ to 2½ hours each, depending upon the responsiveness of the group at the time of the discussion. The discussions offered opportunities for observing patients in action and for determining some of their special needs which could be handled later in individual interviews.

Group discussions covered in sequence the Ten Steps of Recovery around which the program was built and related to an understanding of: (a) The nature and effects of alcoholism; (b) Problems to be met during the recovery program and the years following.

After one or two sessions the patients entered actively into the discussions which were aimed at making each of them realize that:

(1) He must acknowledge the fact that he had lost control of his drinking to the extent that he could no longer stop at will.



Individual counseling

(2) He must accept the fact that he would never be able to drink in a controlled manner again.

(3) He must have a sincere wish to achieve absolute sobriety on a continuous and permanent basis.

(4) He must realize his inability to achieve permanent sobriety through his own efforts alone, and must be willing without reservations to accept such aid as he needed.

(5) He must make as complete an analysis as possible of his own character, personality and temperament, taking care to include traits in himself which he regarded as assets.

(6) He must draw up a plan for setting right any wrongs he had been guilty of doing, being careful in making amends not to injure any of those concerned.

(7) He must establish a daily routine for performing simple recurrent tasks, setting aside time for planning in advance the activities of the day to come, and concentrating his efforts to the greatest possible extent upon the demands of the present.

(8) He must give up his "lone wolf" role and assume an active part among those with whom he associated—friends, relatives, neighbors, fellow workers, etc.

(9) He must be aware always that continuing sobriety alone is not proof of recovery from alcoholism, that it is only an indication that recovery is possible, that to achieve it he must continue unceasingly his efforts to maintain a new way of life.

(10) He must be as selflessly generous toward others as his circumstances permitted, expect no reward except repeated opportunity to serve, continue to make a self-analysis on a daily basis in order to insure a growing breadth of mind as well as a healthy balance between humility and self-esteem; he must make no promises or take any action unless the way ahead was clear; and he must avoid acts which might compel apology from him or needlessly appear to put another in the wrong.

The emphasis in these discussions was aimed at making it unlikely that any patient who completed the Portal House program would in the future be able to find an adequate excuse for drinking. Subsequent testimony indicates that no patient who had a relapse actually enjoyed drinking.

The patient's realization of what a complete relapse might mean to him in the way of physical agony and destruction of every constructive thing he had built up during a period of sober living—the shock of looking into such a future only a few hours away—often brought him back to his senses in time to save himself.

Because the Portal House program dovetailed so well with the program of Alcoholics Anonymous, group discussions were supplemented by one meeting each week with a local chapter of the A. A. as well as Sunday afternoon meetings for former patients and their families. All patients were encouraged to join A. A. as a most effective stronghold of sober living. The role of A. A. in embracing, guiding, instructing and cooperating with Portal House patients cannot be over-estimated. The humility and selflessness of this group, their ever-ready willingness to respond to an emergency—inspired new recruits to help others similarly afflicted.

Psychological, Psychiatric and Other Services

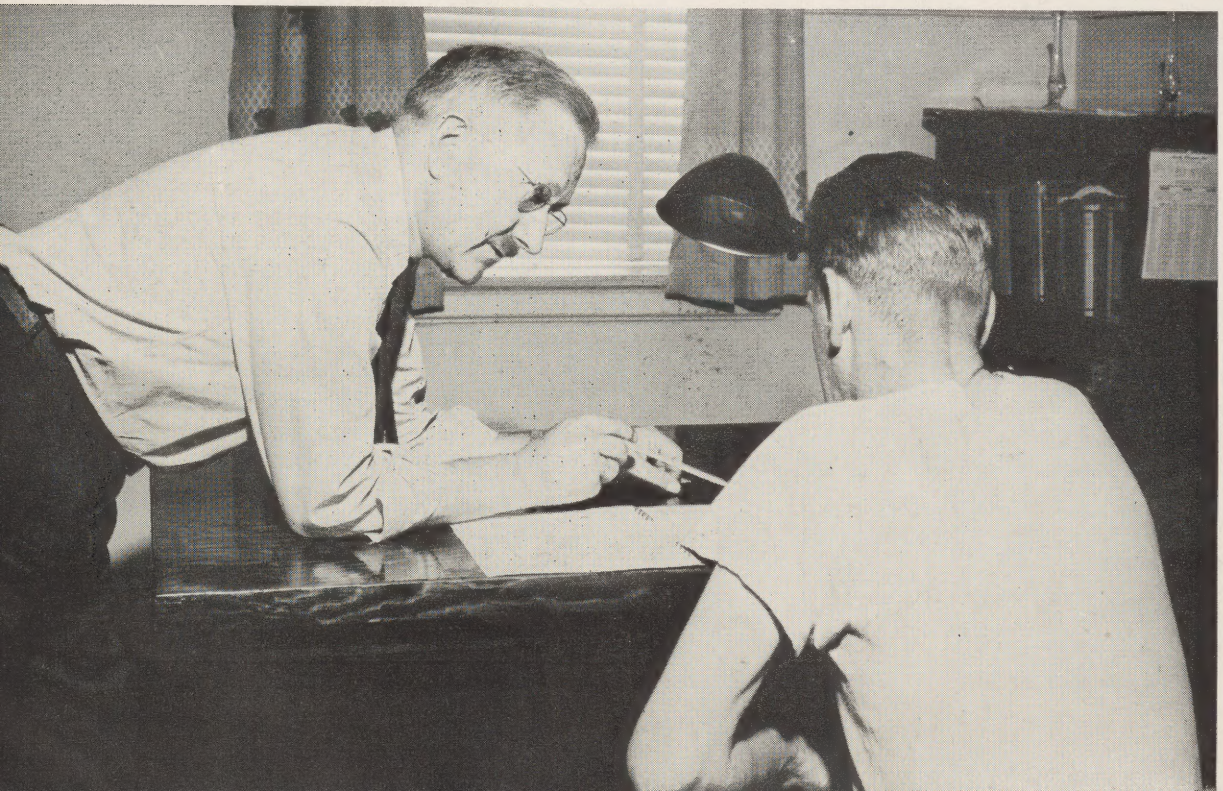
A short cut to a better understanding of the patient's potentialities was accomplished by administering psychological tests. Each patient was tested as to his personality pattern and occupational preference. The psychologist interpreted the tests to the patient with a view to helping his adjustment to the realities of life. The patient was counseled about avocational outlets and was encouraged to pursue those in which he showed aptitude and interest. Director and counselors were guided by the psychologist's recommendation in the total evaluation of the patient's problems.

A diagnostic interview was given each patient by the psychiatrist and the latter's recommendations helped the staff get a closer insight into the patient's personality.

Simultaneously, the patient's medical problems were handled by the Department's staff physicians or he was referred to community clinics for whatever treatment was indicated.

Specialized vocational counseling, based on the patient's past work history or newly discovered aptitudes, helped the Director, counselors, psychologist, psychiatrist and physician to move the patient along the road to recovery.

Psychological testing



Work and Recreation

Work therapy was emphasized in the treatment program. Several types of projects were utilized in connection with the facilities of the Work Therapy Section operated by the Department in the same building: leather work, weaving, model building, clothing repair and alteration, belt making and woodwork. Portal House itself had a small wood shop and several looms. The occupational therapy workshop of the Convalescent Home was used extensively to provide opportunity for exploration of vocational aptitudes.

Other work performed by patients consisted mostly of maintenance responsibilities; mopping and scrubbing floors, washing walls and the insides of windows, painting, cleaning upholstery, building small pieces of furniture, making beds, setting tables, washing dishes, making coffee, and helping to serve. Between five and six hours of work a day were required from each patient. Reasons for assigning this work were carefully interpreted to the patient group within a few days after admission, and a close tie-up was established between the need of the patient to accept social responsibility and the significance of the work he was required to do while in residence.

Without compulsion the patient was helped to feel that he was engaged in useful occupation rather than being "made" to work. He was encouraged to indulge in his own hobbies or to cultivate new hobbies while learning at the same time the art of purposeful relaxation. Recreation was a more loosely organized pursuit. Card games, chess, ping-pong, and reading were popular with most of the patients and it was seldom that much special effort was needed in order to help the patients find activities in which to interest themselves. In good weather a ball game was organized in the park and the patients planted and maintained a large garden in the yard of the Convalescent Home.

Self Government

The device of "self government" enhanced the patients' confidence in the program and served to remind them of similarities between the experience of community living in the treatment center and the phenomenon of being an integral part of the larger community outside.

The patients themselves were given opportunity to put a delinquent member on trial, and it was seldom necessary to change the decisions they made. In general, it may be said that the patients were inclined to be a little more severe with delinquents than the staff and the staff member present at the self-government meetings often acted in the alternative roles of defense and prosecution attorney, so that favorable modification of the patients' decisions were possible without much difficulty when it seemed desirable.

The feeling of self-responsibility was further encouraged by permitting patients to come and go with a reasonable degree of freedom. This policy was successful in 75% of the cases with one or two serious abuses of the privilege in an additional 25%.

Game of chess

Portal house garden

Nutrition Instruction

As part of the rehabilitation program, it was realized that some nutrition education was essential. The aim of discussions was directed toward motivating the men to select adequate meals and to eat regularly after leaving Portal House. The nutritious meals eaten while in Portal House served as the foundation for the discussion on normal nutrition.

Two meetings of about 1½ hours each were held with each group of 22 men. A background of normal nutrition was given. Some of the points covered answered these questions. Why eat? What foods are necessary in a good diet? Are vitamin supplements needed? What is meant by enriched foods? Cost alone is not a measure of the best returns in nutrition and health. Low-cost foods chosen wisely for needed food values may be far better than more expensive foods chosen thoughtlessly. Since most of the men would eat their meals in restaurants, the purchase of low-cost adequate meals was discussed.

To help visualize the suggested meals, colorful food models were used. The charts showing the comparative nutritive value of various foods, e. g., soda pop versus milk, impressed the men. The contribution of milk in the diet was given particular emphasis. A simple demonstration of the preparation of various milk drinks followed the discussion. Material on the normal diet as well as leaflets on food suggestions and sample recipes were distributed. Experimentally, a nutrition movie, MODEST MIRACLE and SOMETHING YOU DIDN'T EAT, was shown to one group. A short discussion followed. The film held the interest of the men.

In preparation for each discussion group, prevailing prices in cafeterias and restaurants were obtained. The men participated freely in discussing their eating habits, food likes and dislikes, and the kind of meals they buy. Many questions were asked about food values. They showed an awareness of food prices and were interested in ways of economizing on restaurant meals without sacrificing an adequate diet.

Suggestions for buying special plate lunches instead of ordering a la carte, buying fruit and milk in the grocery store instead of in the restaurant were well accepted.

It was apparent that adequate meals and their regularity played a substantial part in the rehabilitation of the men.

Follow-Up Care

Following termination of resident treatment and discharge from Portal House, the patient was encouraged to continue contact with an Alcoholics Anonymous group in his neighborhood. He was invited to return to Portal House whenever he felt the need for consultation about his drinking or personal problems. Director and counselors made every effort to assist and advise him.

Before leaving Portal House the patients' problems were interpreted to prospective employers, landlords, friends and relatives. Families of patients were oriented in a better understanding of alcoholism and the ways in which they could help retain recovery.

In some cases this newly acquired understanding brought about family reunions after long separations.

The Results

It is unquestionably too early—on the basis of only one year's experience—to draw any proper conclusion as to how permanent will be the effect of the treatment received at Portal House by 163 patients. But it can be said that all signs to date are most encouraging.

Of the first 18 patients who received treatment more than a year ago, the record shows that 9 have remained continuously sober and gainfully employed since their discharge. All are active members of Alcoholics Anonymous and return frequently to Portal House. The remaining 9 of the original 18 have enjoyed varying success, in no case suffering a serious enough relapse to necessitate reapplication for public assistance.

Of the 83 patients treated during the first six months of the experiment, 28 have remained continuously sober since their discharge, 27 others are regarded as improved inasmuch as they, also, have not had to reapply for assistance, and the remaining 28 have either had serious relapses or disappeared, or both.

Indications are that the foregoing results will hold true in the cases of the 80 patients who were treated during the last six months of the experiment.

It is worthy of note that the cost to operate Portal House for one year was approximately $53,000; that had the Department been obliged to support the 163 patients and their families on the public assistance rolls for that period the cost would have been approximately $68,000.

Based on the year's experience, it can be said that alcoholics can be helped, that they are worth helping, and that it is less expensive to treat those who are treatable than to carry them indefinitely on the public assistance rolls.

The following tables describe the 163 patients by type of drinker, physical conditions and response to treatment.

Definitions and Analysis of Patient Group

Alcohol Dependent: One who depends upon alcohol regularly to ease certain situations, overcome inertia, aid in getting sleep, stimulate appetite routinely, etc., but who does not drink excessive amounts of alcoholic beverages ordinarily.

Chronic Excessive Drinker: A heavy drinker who has begun to show symptoms of social isolationism, immaturity of reactions, both to situations and to people; evinces extreme egocentricity and exhibits abnormal responses while drinking such as immoderate loud and long laughter, or moroseness, irrational behavior, etc.

Compulsive Drinker: A heavy drinker who can no longer control either his drinking or his behavior while drinking, whose life is so maladjusted generally that life itself appears to be the insurmountable problem waiting to be solved. This drinker is desperate for *any* solution to his all-encompassing problems, no matter how irrational the solution might be.

Chronic Alcoholic: May be chronic excessive or a compulsive drinker who has developed permanent physical and/or mental disorders as a result of heavy prolonged drinking.

Symptomatic Alcoholic: An individual whose alcoholism is one symptom of another more basic disease or maladjustment which, if successfully treated, may be expected to eliminate the alcoholic problem as well. Such underlying disorders may be among the following, and similar categories: psychoses, marked schizoid and paranoid trends, extreme anxiety states, pronounced hysteria, etc.

CLASSIFICATION OF PATIENTS

Of the 163 patients, 66 or 40.5% of the total were regarded as being compulsive drinkers in the light of the preceding definitions. Most of these fell into the age groups between 36 and 50 years; two-thirds of them between 36 and 45 years, with 21 patients in each of the 5 year ranges in this 10 year span.

Chronic excessive drinkers numbered 42 or 25.8% of the total, two thirds of whom were found to be less than 45 years of age, as would be expected, since the ages of the chronic excessive drinkers were in general somewhat below those of the compulsive drinkers, who represent a greater degree of deterioration.

Twenty seven of the 35 cases of chronic alcoholism (three fourths of the cases) were between the ages of 40 and 60 years, and in general this category was slightly older than the category of the compulsive drinker. It represents a further step in the direction of deterioration. Almost all of the cases of symptomatic alcoholism were in groups under the age of 45 years, with a majority even under the age of 41 years. This can be anticipated since symptomatic alcoholics are likely at advanced ages either to be restored to health or out of contact with society altogether. The two cases listed over 46 years of age may be construed as doubtful and may actually represent cases of chronic alcoholism in which deterioration has been very marked with symptoms resembling those of some other disorder. The unknown case was in residence for too short a time to permit any determination of proper classification.

Types of Patients by Age Groups

Age Groups	Alcohol Dependent	Chronic Excessive	Compulsive	Chronic Alcoholic	Symptomatic Alcoholic	Un-known	Total
Under 20	—	—	—	—	—	—	—
20 - 25	—	—	—	—	—	—	—
26 - 30	—	1	1	1	3	—	6
31 - 35	—	10	5	1	3	—	19
36 - 40	—	6	21	6	6	—	39
41 - 45	—	11	21	12	5	1	50
46 - 50	—	9	10	9	1	—	29
51 - 55	—	5	7	5	1	—	18
56 - 60	—	—	1	1	—	—	2
61 and over	—	—	—	—	—	—	—
TOTAL	—	42	66	35	19	1	163
Per Cents	—	25.8	40.5	21.5	11.6	0.6	100%

ADJUSTMENT OF PATIENTS TO RESIDENCE TREATMENT

There appeared to be a definite improvement of attitude during the residence period in the case of 96 (58.9%) of the patients. The compulsive drinkers seemed to show up best on this evaluation. It may be assumed that the chronic excessive drinkers are not so likely to feel the need for absolute surrender to a new way of life as the compulsive drinkers. The chronic alcoholics also show up well on this evaluation as could be expected. The symptomatic alcoholics had the poorest record.

Only 33.1% of all of the patients took an active interest in Alcoholics Anonymous during their residence; that is, went to A.A. meetings outside of Portal House on their own initiative. All patients attended A.A. meetings which were held in Portal House unless they were especially excused. Attendance was optional at the one discussion held during the patients' residence that was religiously oriented. Every patient elected to participate in it.

On resourcefulness, all groups were quite low, but it must be remembered that alcoholics are out of the habit of exercising their resourcefulness, except in certain narrow circumscribed ways for from 10 to 15 years uninterruptedly. The re-birth of this resourcefulness is a slow process, and it was encouraging to see as much of it evident as there was. For those who were able to gain sufficient freedom from old habit patterns to show resourcefulness, this flexibility was partial insurance against the relapse often excited by the alcoholics' lonesomeness and boredom during the early stages of recovery.

Adjustment by Type of Patient

Type of Drinker	Chronic Excessive	Compulsive	Chronic Alcoholic	Symptomatic Alcoholic	Total	% of Total
	(42)	(66)	(35)	(19)	(163) *	
Improvement of Attitudes	25	43	23	5	96	58.9
Active Participation in A.A.	9	28	13	4	54	33.1
Deterioration of Attitudes Apparent	3	7	3	8	21	12.9
No Observable Change in Attitudes	14	18	9	5	46	28.2
Wrote Autobiography	19	30	25	9	83	50.9
Attempted Making a Self-Evaluation	23	34	27	9	93	57.1
Active in Work and Recreation Program	15	18	14	4	51	31.3
Moderately Active	22	34	17	7	80	49.1
Relatively Inactive	4	10	6	9	29	17.8
Resourceful at Discovering Activities to Interest Self	9	8	3	2	22	13.5
Moderately Resourceful	19	23	16	6	64	39.3
Non-Resourceful	13	30	16	12	71	43.6

*1 Unknown classification

PHYSICAL CONDITION OF PATIENTS

Nearly one-third of all patients were between the ages of 41 and 45 years. Only a little more than one-third (39.4%) were below this age range; the remainder (30.1% of the total) were over the age of 46 years and less than 61 years of age. These data indicate that so far as age was concerned, the patients served by Portal House comprised a more or less "normal" alcoholic group.

Analysis of the subjects' physical condition shows that only 71 (43.6%) of the total of 163 patients were classified as physically non-handicapped (using vocational placement standards as a criterion); 20 (12.3%) had severe disabilities; 47 (28.8%) had moderately severe disabilities; and 25 (15.3%) had a combination of two or more minor disabilities which together indicated individualized placement efforts would be necessary.

Except for individuals classified as chronic alcoholics, the disabilities represented in these tables were not either directly or indirectly attributable to excessive and uncontrolled drinking, so far as could be determined.

Severe disabilities consisted of such defects as an amputated limb, serious heart damage, etc. Moderate disabilities included moderately severe varicose veins, blindness of one eye, lameness of one leg, etc. Minor disabilities ranged from hernias to mild forms of internal disorders, each of which may be inconsiderable in itself as a vocational handicap, but in addition to one or more other similar disabilities, becomes part of an aggregate that must be regarded as vocational or industrial handicap, and one which is only slightly less significant, probably, than disabilities classified as moderately severe.

Physical Condition of Patients by Age Groups

Age Group	% of Total	Total	Severe Handicap	Moderate Handicap	Minor Multiple Handicaps	No Physical Handicaps
26 - 30	3.7	6	1	1	—	4
31 - 35	11.7	19	2	4	3	10
36 - 40	23.9	39	5	9	6	19
41 - 45	30.7	50	5	13	5	27
46 - 50	17.8	29	4	11	7	7
51 - 55	11.	18	4	7	3	4
56 - 60	1.2	2		2	—	—
Totals	100.	163	21	47	24	71
Per Cents		100.0	12.9%	28.8%	14.7%	43.6%

RESPONSE TO TREATMENT

Patients between the ages of 41 and 50 years gave the most satisfactory response to treatment from the standpoint of age groups. Twenty seven out of the 47 apparently arrested cases fell in this age range. The groups aged 36 to 45 showed the greatest improvement short of complete arrestment, but also were responsible for the highest percentages of failures.

Generally speaking, the middle to late middle age groups seemed to give the best response to treatment. Individuals under the age of 40 years were less willing to accept the self-responsibility necessary to recovery. Even when they were able to accept the need for "settling down" on an intellectual basis, they were in too much conflict emotionally to act out the sober role successfully. The high percentages of improvement shown in these lower age groups give promise for many later recoveries.

Response to Treatment by Age Groups

Age Groups	Apparently Arrested	% of Age Group	Improved	% of Age Group	Unimproved	% of Age Group	Total in Age Group
26 - 30	1	16.7	2	33.3	3	50.0	6
31 - 35	6	31.6	8	42.1	5	26.3	19
36 - 40	6	15.4	15	38.5	18	46.1	39
41 - 45	14	28.0	13	26.0	23	46.0	50
46 - 50	13	44.8	8	27.6	8	27.6	29
51 - 55	7	38.9	5	27.8	6	33.3	18
56 - 60	—	—	—	—	2	100.0	2
Total	47		51		65		163

EARNING CAPACITY LOST BY PATIENTS THROUGH EXCESSIVE DRINKING

Immediately following the conclusion of the first step covered in the discussion group series, patients were requested to answer a questionnaire which related in general to their drinking habits, behavior, and experience. In one section of the questionnaire, the patient was asked to estimate the number of days lost from work each year as a direct result of drinking. Detailed instructions were given to insure the estimates being as nearly correct as possible.

This section of the questionnaire was answered satisfactorily by 113 patients, and the results tabulated showed 30% of the patients lost between one and two years of employment because of drinking, and 33.6% lost from two to three years. The median loss of employment was two years and five months. In two instances over 90% of the working time available was lost; in only seven cases was the loss less than the equivalent of one year of employment.

The loss of work per year amounted to 2.9 months, or 89 days. The loss of productivity each year for the 163 patients served by Portal House amounted to about 40 man years per annum (or 430 man years within the 10 year period ending in 1947). If one assumed that the average income of this patient group was normally about $2,000 per annum, the earning power lost because of heavy drinking would aggregate about $80,000 per year for the group of 163 patients served by Portal House during the past year. The indirect losses, of course, are practically inestimable, but would certainly increase this estimated direct loss by several times.

Selden D. Bacon, Executive Secretary of the Yale Plan, has asserted that an out-patient facility which dealt with 300 patients a year at a cost of $25,000 would pay for itself if it were effective in only 10% of the cases. On this basis, an in-patient facility like Portal House will pay for itself if it effectively arrests drinking on the part of 20% of its patients for one year. It appears then, considering the measurable results of Portal House activities, that this treatment program has been an eminently sound investment from the standpoint of community, social and economic welfare.

PSYCHOLOGICAL ANALYSIS OF PATIENT GROUP

Through psychological measurements it was possible to make some objective observations of the effect that the environment of the resident treatment in general had on the patients as well as of their personality characteristics.

*Personality Characterizations of Patients***

The **common personality pattern** observed in most of the individuals was that of a highly self-centered, emotionally immature personality, lacking ability to put himself in the other person's place, restless, tense, and predisposed to fear. In varying degrees this pattern prevailed throughout.

The **relatively normal individual** tended to become readily exhausted emotionally; outraged by and fearing his own behavior, but more particularly its own consequences to himself, he appeared to be full of anxieties—28%.

The **individual becoming dull of understanding** was one who appeared to have lost the ability to make sense out of situations and circumstances to a greater or less extent; he appeared to have lost inner balance. He showed lack of resilience in comprehension and wasted his energy through compulsive thoughtless action to which he might be prompted by any stimulus which was exerted from outside of himself—27%.

The **withdrawing personality** might be described as an emotionally stifled person who found difficulty in making and sustaining social contacts; he showed a tendency toward lack of inner balance, but exhibited responsiveness to memories, imagery, etc. He responded with anxiety and feelings of inferiority to what he regarded only as the puzzling world existing outside of himself—10%.

The **personality drifting into unreality** showed an even greater trend toward withdrawal which resulted in wishful thinking as a substitute for rational activity in meeting his needs. Closed within his own private world he was clearly at odds with his environment—7%.

The **personality reduced to apathy** was one whose normal expression had been largely replaced by anxieties, and whose personality had become so severely impoverished as to make his existence apparently almost unworthy of the effort made to maintain it—5%.

The **over-actively functioning personality** was one in which feeling and imagination appeared to be highly pitched with an immoderate drive toward activity for its own sake, alternating between the extremes of brilliance and nervous exhaustion—2%.

The **personality in which over-activity had become an obsession** showed greatly weakened restraint because of the accelerated momentum of an imagination which had outrun reason and fostered wishful thinking about a private world that imposed no limitations on one's extravagance except for his need to keep a precarious toehold on reality—12%.

The **mentally diseased patient** resembled an individual who might have been in the acute delirium of alcoholism, but with him the signs of dementia would persist to such an extent that an exhaustive phychiatric examination was indicated—9%.

Intelligence and Related Factors for Group of 83 Patients

1. Average Intelligence: Corresponds to I.Q. 1.16 ("Bright normal" adult). The intelligence of the middle 50% of the group ranges from I.Q. .97 (average adult) to I.Q. 1.23 (superior adult). Lowest: I.Q. .89; Highest I.Q. 1.40.

2. Average available intellectual energy (available intelligence): Corresponds to I.Q. .80-.90 (dull normal adult): Lowest: I.Q. .72; Highest I.Q. 1.06.

3. Mental deterioration: Found in 31 out of 83 cases (37.3% of entire group). The "deterioration" of the middle 50%: From 6.75% to 20.25%. (Mental deterioration is here a measure of premature slowing down in mental ability.)

4. School level achievement: Average of First Year of High School. The middle 50% ranges from 8th grade up to 3rd year of High School. Lowest: 3rd grade; Highest: 5 years of graduate work.

Personality Changes During Residence

Continuous reminders *to practice living each day out fully* were aimed at impressing the patient with his need to avoid existing in either the future or the past in order to *insure freedom from accumulating tensions and anxieties* that would drain away energy needed to meet the demands of the present. Retesting of patients after four to six weeks of residence revealed significant changes suggesting that there were new developments within patients generally while they were in residence.

(1) There were measurable indications of a general increase in emotional maturity on the part of the patient.

(2) Tensions and anxieties change character frequently with an intensified effect on the patient. Activity in the fellowship of A.A. provided the avenue needed for guiding the patient through this period, in many instances.

**The tests used were Rohrschach Psychodiagnostic Test, Pressey X-O Tests I, IV, Form A Investigating the Emotions; Wechsler-Bellevue Adult Intelligence Test; SRA Primary Mental Abilities Test.

Based on records of 100 patients, June 1947 to June 1948.

(3) The patient tended to attempt taking in more of his environment than he could manage, or to become fascinated by insignificant, often unreal, ideas that offered temptation in the way of wishful thinking; such ideas were impermanent, however, and would rapidly give way to more practical point of view.

(4) The patient's intellectual energy in general showed a marked increase, but with considerable variance among individuals.

(5) An unconscious rebelliousness seems to be replaced in the patient by a deep yearning to belong, a new awareness of social canons, and a tendency to "go along" instead of insisting on his former highly individualized pattern of behavior.

(6) A growing sense of reality was especially notable among those patients who had appeared to have sunk into apathy.

All in all the changes observed to have taken place in the personalities of the patients might be reasonably regarded as great and real gains, even though in two of the four statements given above, it would appear that the patient had lost ground rather than made a gain. Actually, even these apparently adverse developments are hopeful indications so far as eventual recovery is concerned.

COMPARATIVE COSTS OF EXPERIMENT

What were the costs of the experiment? What would have been the costs to the Department of Welfare and to the community had there been no alcoholic therapy project for the 163 clients eligible for general assistance who were admitted to Portal House?

Total costs of the Portal House Program for these 163 patients in the period from June 1947 to June 1948 amounted to $52,800. This figure does not include investments in equipment and fixtures and depreciation of investments. It covers:

1. Costs of examination of eligibility for both general assistance and alcoholic therapy under the Department of Welfare programs. These intake costs amounted to about $8.50 per case.
2. Costs of residence in Portal House including the "transition periods" when clients sought employment and living arrangements outside of Portal House. These costs amounted to about $4.00 per day.
3. Costs of contact with patients by Portal House staff subsequent to Portal House residence. These costs averaged about $1.00 per day.
4. Costs of general assistance to patients and their families during and after Portal House supervision including administrative costs. These costs amounted to an average of about $.80 a day per patient.

Table I. Cost of Program June, 1947 to June, 1948

Classification	Amount
Total	$52,800.
Examination of Portal House applications	1,400.
Care during:	
Residence Period	27,700.
Follow-up Period	6,700.
General Assistance[a]	17,000.

[a] Covers support under the general Assistance program provided patients and their families during the period of residence and until the case was closed or the end of the Portal House experiment.

Table II. Days of Supervision for 163 Patients, by Stage of Treatment

Stage of Treatment	Days under Supervision
All Stages	13,000[a]
Residence:	
Full time	5,100
Transition	1,900
Follow-up	6,800

[a] Following Portal House supervision general assistance continued for 8,000 additional days up to June 1948 or closing of case.

Without the alcoholic therapy program the Department of Welfare would have supported through general assistance each of the 163 unemployable patients, and in 23 cases their families, from date of Portal House admission to June 1948 or in certain cases earlier. The exceptions might be considered to be the four patients who died from causes other than alcoholism, the nine who were transferred for care in a State Hospital, and the 26 who left with whereabouts unknown. [1] For these the assumption is made that general assistance continued until the date the case was actually closed.

Based on the foregoing assumptions, administrative and assistance costs of the general assistance program without alcoholic therapy would have amounted to about $68,700 for approximately 26,000 days of care, or about $2.64 per day.

Table III. Estimated Cost of Support Under the General Assistance Program for the 163 Portal House Cases Had There Been No Portal House During Period June, 1947 to June, 1948[a]

Total	$68,700[b]
Assistance	62,200
Administration	6,500

[a] Based on the assumption that the 163 persons given treatment at Portal House would have received continuous general assistance from the date of admission through the survey period except for those cases for which it is assumed general assistance would have been discontinued earlier.

[b] Covers cost for a total of 26,000 days of care.

[1] Those who died had been under care from 40 to 150 days; those transferred to a State Hospital from 59 to 169 days; those who left with whereabouts unknown from 4 to 144 days.

The difference then of $15,900 between costs under the general assistance program without Portal House estimated to be $68,700 and the costs of the Portal House program amounting to $52,800 represents savings to the Department of Welfare in a year's operation of the Portal House demonstration.

Of course, these savings are minimum, when it is considered they would be increased with the extension of time. Continuance of the Portal House demonstration for persons who were still in residence and others still under supervision at the close of the demonstration period would result undoubtedly in a higher proportion of patients who were employed and whose chronic alcoholism was apparently arrested, thereby reducing Portal House costs per case. And a consideration of only general assistance costs over a longer period of time would show these alternative costs to be higher.

Beyond savings in dollars and cents to the Department of Welfare should be considered also what the program meant to patients and their families and to the community.

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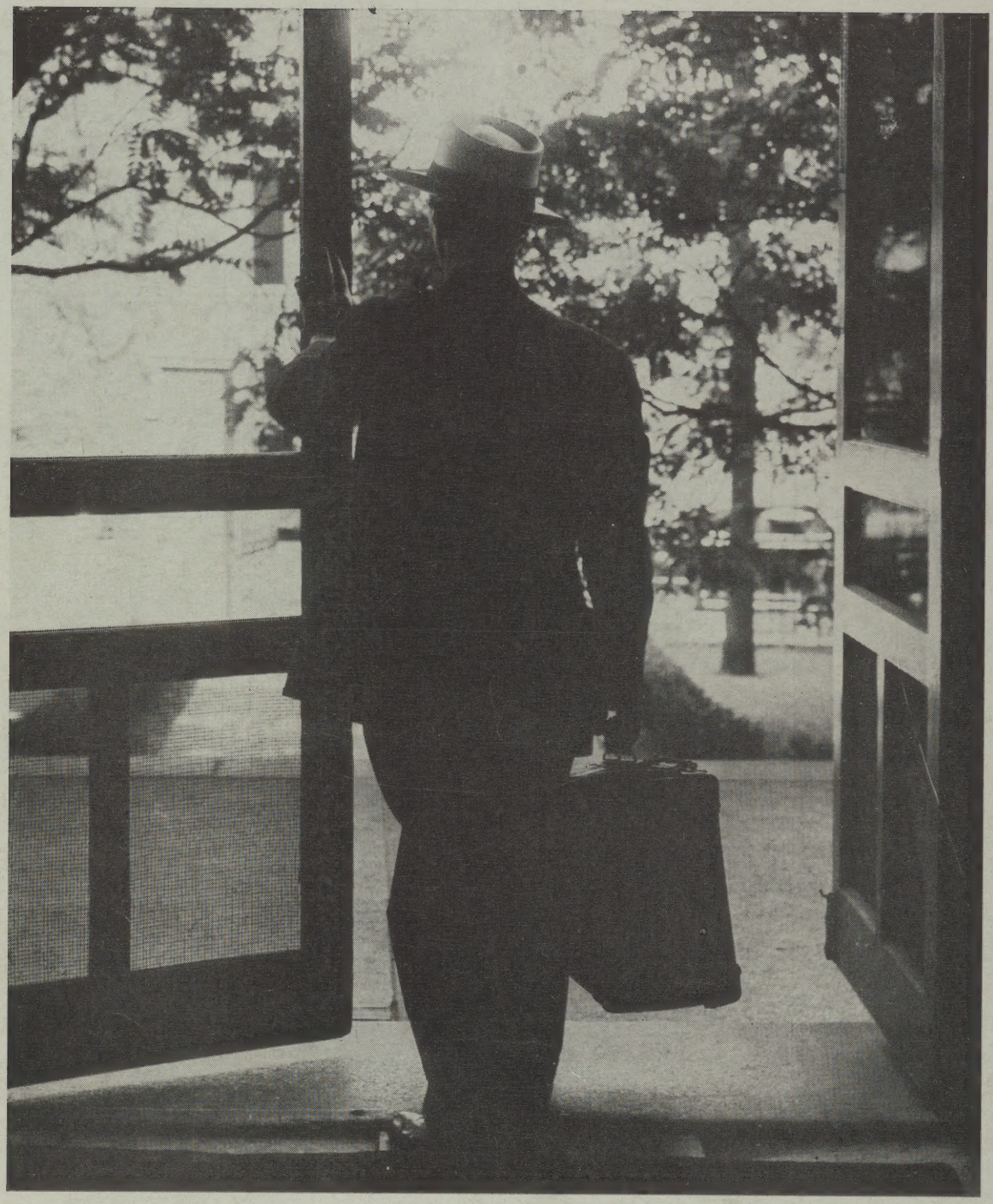

A fresh start